

March 29, 2012

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

Re: Notice of *Ex Parte* Communication, WC Docket No. 02-60

Dear Ms. Dortch:

On February 22, 2012, John Gale of the Maine Rural Health Research Center, Cutler Institute for Health and Social Policy, Muskie School of Public Service, University of Southern Maine, spoke via telephone with Christianna Barnhart, Linda Oliver, Samantha Flanzer, and Chin Yoo of the Wireline Competition Bureau. Mr. Gale is a Health Services Researcher with extensive experience in rural health policy. The purpose of the call was to discuss the telecommunication needs of rural health care providers, specifically with regard to rural health clinics, in response to the Commission's July 15, 2010 Notice of Proposed Rulemaking in the above-referenced docket.

Mr. Gale provided a general overview of the "Rural Health Clinic" (RHC) designation under Centers for Medicare and Medicaid Services (CMS) rules. He said the program originated in 1977, in order to improve access to primary care services for rural Medicare/Medicaid-eligible recipients. He highlighted the advantages that the formal RHC classification provides to rural health care providers, including enhanced cash flow and stability due to cost-based reimbursement and support for use of mid-level practitioners (*i.e.*, nurse practitioners, nurse midwives, and physician assistants).

Mr. Gale stated that there are approximately 3,950 RHCs nationwide.¹ Mr. Gale said there are two different types of RHCs: "independent" (freestanding) small physician practices and "provider-based" practices. Independent practices can be either publicly or privately owned, and many operate as small physician practices. Provider-based practices are largely owned and operated under the auspices of a hospital, and must operate under their clinical supervision. He stated that about 51 percent of all RHCs are independent, and 49 percent are provider-based. Mr. Gale estimated that about 30-40 percent of all independent practices are public or not-for-profit. On the other hand, Mr. Gale stated that almost all provider-based RHCs are public or not-for-profit, as they are generally either owned by municipalities or counties or are 501(c)(3) entities. They are located in every state except Delaware, Rhode Island New Jersey, Maryland, and Connecticut.

Mr. Gale described the small size of RHC practices. He said that the average number of physicians at a typical RHC is 2.8 physicians and roughly 1-1.5 mid-level practitioners.² Mr. Gale stated that due to their small size and limited financial resources, small RHC clinics are less likely to have

¹ Source: Centers for Medicare and Medicaid Services (CMS), Medicare Certified Rural Health Clinics, January 2012, available at <http://www.cms.gov/MLNProducts/downloads/rhclistbyprovidername.pdf>. Attachment 1 to this letter contains Mr. Gale's listing of state-by-state RHC counts based on this January 2012 CMS data.

² JOHN A. GALE & ANDREW F. COBURN, THE CHARACTERISTICS AND ROLES OF RURAL HEALTH CLINICS IN THE UNITED STATES: A CHARTBOOK 3 (Univ. of S. Me., 2012), available at <http://muskie.usm.maine.edu/Publications/rural/RHChartbook03.pdf>.

access to broadband and/or the equipment necessary to utilize electronic health records or telehealth applications. Again, citing the Southern Maine January 2003 RHC report, Mr. Gale noted that on average, RHC total yearly expenses exceeded revenue. Additionally, he highlighted the time and productivity constraints that RHC providers face. Mr. Gale estimated that the majority of RHC practitioners must see five to six patients per hour to remain financially sustainable, leaving little time to devote to technological upgrades or meetings with consultants. He also discussed the possibility that many RHC physicians may be nearing retirement and thus are left with little incentive to adopt electronic medical records let alone to achieve "meaningful use." Mr. Gale did state that provider-based RHCs are more likely than independent small physician practices to utilize telehealth applications.

Mr. Gale noted that there is not a lot of data on broadband use by RHCs. He is currently collecting data from RHCs on their use of health information technology. The very preliminary results, based just on early responders (who may be atypical of the group), indicate that about 38% of RHCs have DSL, 22 % have T-1 connections, another 14% have cable modem services, and 15 % were not sure.

Mr. Gale was asked whether he was aware of any informal networks among RHCs that might have been developed to pool resources and technical expertise in order to support the implementation of electronic medical records and achievement of meaningful use. Mr. Gale was not aware of any such networks, but he believed that such informal networks were largely occurring among hospitals. He noted that RHCs might be affiliated with those hospitals, however.

Mr. Gale also provided a broad overview of federally qualified health centers (FQHCs) and critical access hospitals (CAHs). Mr. Gale stated that while there are 3,800 RHCs, there are only 1,600 rural FQHCs³ and approximately 1,300 CAHs nation wide.⁴ Regarding FQHCs, he noted that they are generally more prevalent in urban areas than in rural areas, because they are typically defined within a set geographic area and are required to serve an adequately-sized vulnerable population group. He observed that there is somewhat of a trend for RHCs to convert to FQHCs as they often receive a higher level of reimbursement for costs as FQHCs. With respect to CAHs, Mr. Gale reviewed their legislative history and noted that CAHs are also located in every state except Delaware, Rhode Island, New Jersey, Maryland, and Connecticut. Mr. Gale referenced fact sheets regarding RHCs, FQHCs, and CAHs, which are attached. He also referenced a website on CAHs, www.flexmonitoring.org.

Respectfully submitted,

 /s/
Linda L. Oliver
Attorney Advisor
Telecommunications Access Policy Division
Wireline Competition Bureau

Attachments

³ See e.g., CRITICAL ACCESS HOSPITAL REPLACEMENT PROCESS 3 (U.S. Dep't of Health and Human Serv., Health Res. and Servs. Admin., 2010)

⁴ See e.g., RHC AT THE CROSSROADS: NOSORH REGION C ANNUAL MEETING 4 (MUSKIE SCH. OF PUBLIC SERV., Me. Rural Health Research Ctr., 2011).